APPENDIX 6

Edits And Rejections

Overview

In business today, there are hundreds of different systems that all process data differently. Because of that difference there are also different requirements imposed on the EDI submissions from trading partners. Consequently, there are also variances in the reporting mechanisms that are intended to aid submitters in verifying the compliance of their submissions with the EDI requirements of the receiving entity, and the acceptance or rejection of their submissions by the receiving entity.

Often, response reports are sent to submitters on paper and lack the relevant information needed to resolve issues with the transactions that were rejected on the front end. With the advent of HIPAA and the standardized transactions, we now have the ability to standardize the front-end edits as well as the acceptance or rejection reports resulting from those edits. Given that healthcare trading partners will, at a minimum, need to supply standard data content in HIPAA-mandated transaction sets, there is a clear need to standardize the front-end edits and the reporting of the result of such edits.

Once the healthcare industry standardizes front-end edits and reports, we will see a significant reduction in front-end rejected transactions due to the correlation of the editing rules between sender and receiver systems. We will also see expedited correction and resubmission of erroneous transactions. This will result in many benefits to the industry including:

- Accelerated adjudication for claims transactions
- Eased implementation of automated eligibility inquiries
- Automated requests for prior authorization
- More timely claim adjudication status inquiries/responses
- A reduction in inquiries from trading partners regarding edits and reported information.

The Illinois Department of Healthcare and Family Services (HFS) is a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as a payer of medical services. To insure the HFS is compliant with the requirements for Electronic Data Interchange (EDI) standards, each transmission will be edited prior to entering the HFS Medicaid Management Information System (MMIS). These edits will be performed in stages, with a unique method of communication used to relay information back to the sender regarding errors, if applicable. Rejection of non-compliant transactions also reduces the opportunity for the providers to submit transactions that would place them in violation of the HIPAA Final Rule.

In the health care industry today, many entities may interact with data between the provider and payer. These entities include billing agents, clearinghouses, etc… As a business associate of the provider these entities are obligated to assist the providers in the creation of a compliant transaction prior to submission to a payer. In many instances, these “intermediate entities” will reject syntax errors at a claim or service level so that the provider may correct errors. This relationship should enhance the syntax compliance of each transaction before it is submitted to a payer.

This document contains subtopics that will explain and provide examples of each level of editing that will occur on a HIPAA file transmission submitted to the HFS. Each subtopic also contains information about the functional acknowledgement that will be created to communicate edit information to the submitter. Because HIPAA transactions have introduced terminology that may not have been widely utilized in the industry in other formats, the following is a crosswalk between X12 terminology and more common terms in use today. This crosswalk will assist in bridging the communication gap that may exist in the initial stages of HIPAA implementation with the HFS.

X12 Term	X12 Header/Trailer ID's	Current Term(s)
Interchange Envelope	ISA/IEA	File
Functional Group	GS/GE	Batch
Transaction Set	ST/SE	Sub-Batch

You are **strongly** encouraged to review and understand the Key Terms section of this document prior to proceeding.

The Additional Information section notes a WEDI white paper that explains an industry view of the editing mandated under HIPAA. Finally, you should carefully review the Recommendations section which is a list of suggested approaches to implementation that may ease the transition to HIPAA mandated EDI and reduce the amount of front end rejections.

INTERCHANGE LEVEL ERRORS

Certain edits must be enforced within the Interchange to ensure proper communication of electronic transaction between the Submitter and the Receiver. These edits check the ISA and IEA level segments and data content within these segments. Any X12 syntax errors at this level will cause the **entire interchange** to be rejected with no further processing. Since further processing is halted, the expected X12 response transaction may never be received (i.e. an 837 would not appear on an 835 or paper remittance advice; a 271 would not be received in response to a 270; a 277 would not be received in response to a 276). Most, but not all, edit failures of this type will be reported in the TA1 functional acknowledgement.

Examples:

- Missing/Invalid Header (ISA) or Trailer (IEA) Segment
- Missing/Invalid data within the ISA or IEA Segment

Pictorial Representations:

Figure 1.1

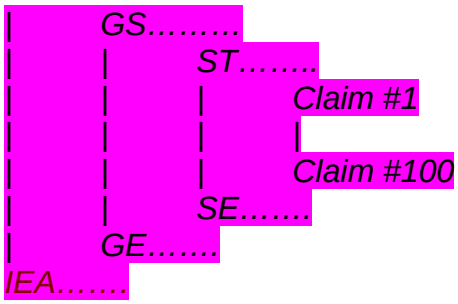


Figure 1.1 – Missing Interchange header (ISA). In this example, critical trading partner information is not present making it impossible to know if this is a valid transmission. X12 requires this information be present. This will result in the rejection of the entire Interchange. Since the trading partner information was not present a TA1 cannot be generated.

Figure 1.2

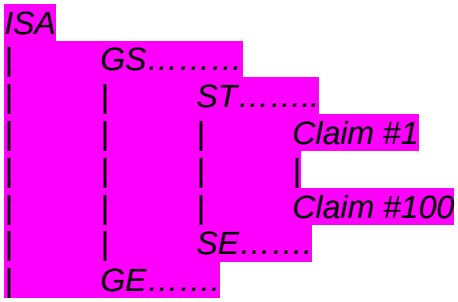


Figure 1.2 – Missing interchange trailer (IEA). In this example, the IEA trailer segment is missing. X12 requires this information be present. This will result in the rejection of the entire interchange. Since trading partner information was present in the ISA a TA1 will be generated.

FUNCTIONAL ACKNOWLEDGEMENTS AND HIPAA X12 EDITS

HIPAA X12 errors can cause the **entire** Functional Group (GS/GE) or **entire** Transaction Set (ST/SE) to be rejected, depending on the type of error, with no further processing. Since further processing is halted, the expected X12 response transaction may never be received (i.e. an 837 would not appear on an 835 or paper remittance advice; a 271 would not be received in response to a 270; a 277 would not be received in response to a 276). Most, but not all, edit failures of this type will be reported using the 997 and/or 824 transaction(s). Generally, the 997 will report on acceptance/rejection at a high-level. The 824 is used to supplement the 997 by providing very specific error information, data element by data element, allowing for easier analysis and correction.

Certain edits must be enforced within Functional Groups, Transaction Sets, Segments and Data Elements to ensure proper communication of electronic transactions between the Submitter and the Receiver. This includes editing of the EDI file for valid segments, segment order, element attributes, testing for numeric values in numeric data elements, validation of X12 syntax, and compliance with X12 rules. This will validate the basic syntactical integrity of the EDI submission. These edits are often referred to as the WEDI types of HIPAA validation. At present, the Department intends to enforce WEDI types 1-4.

EDI Syntax Integrity Validation (WEDI Type 1)

Editing of the EDI file for valid segments, segment order, element attributes, testing for numeric values in numeric data elements, validation of X12 syntax, and compliance with X12 rules. This will validate the basic syntactical integrity of the EDI submission. Edit failures will result in the rejection of the **entire** transaction set (ST-SE) containing the error(s).

HIPAA Syntactical Requirement Validation (WEDI Type 2)

Editing for HIPAA Implementation Guide-specific syntax requirements, such as limits on repeat counts, used and not used qualifiers, codes, elements and segments. Also included in this type is testing for HIPAA required or intra-segment situational data elements, testing for non-medical code sets as laid out in the Implementation Guide, and values and codes noted in the Implementation Guide via an X12 code list or table. Edit failures will result in the rejection of the **entire** transaction set (ST-SE) containing the error(s).

Balancing (WEDI Type 3)

Editing the transaction for balanced field totals, financial balancing of claims or remittance advice, and balancing of summary fields, if appropriate. An example of this includes items such as all claim line item amounts equal the total claim amount. (See pages 19-22, Healthcare Claim Payment/Advice - 835 Implementation Guide for balancing requirements of the 835 transaction.) Edit failures will result in the rejection of the **entire** transaction set (ST-SE) containing the error(s).

Situation Testing (WEDI Type 4)

The editing of specific inter-segment situations described in the HIPAA Implementation Guides, such that: If A occurs then B must be populated. This is considered to include the validation of situational fields given values or situations present elsewhere in the file. Example: if the claim is for an accident, the accident date must be present. Edit failures will result in the rejection of the **entire** transaction set (ST-SE) containing the error(s).

The following examples and pictorial representations are meant to further define the validation that will occur as a result of compliance with the HIPAA and X12 requirements.

Examples:

- Invalid or missing Functional Group (GS/GE) information
- Invalid segments or segment order

- Invalid data element attributes

Pictorial Representations:

Figure 2.1

ISA……
| *GS……*
| | *ST……..*
| | | |
| | | |
| | *SE……*
| *GE..(Data indicates 9 Transaction Sets (ST/SE) in this functional group (GS/GE).*
IEA……

Figure 2.1 – Invalid GE segment. In this example, the GE segment shows there should be nine Transaction Sets (ST/SE) within the Functional Group (GS/GE) and only one is present. X12 requires that the number of Transaction Sets within a Functional Group balance with the trailer segment to ensure proper communication of information. This will result in the rejection of the entire Functional Group (GS/GE). One 997 acknowledgement is generated for the transmission containing the rejection information.

Figure 2.2

ISA……
| **GS……..**
| | *ST……..*
| | | *NM1……*
| | | *BHT……..*
| | | |
| | *SE……*
| | **ST……..**
| | | **BHT……..**
| | | **NM1……**
| | | |
| | **SE……**
| **GE……**
IEA……

Figure 2.2 – Invalid segment order. In this example, the NM1 should not appear before the BHT segment. X12 requires a certain hierarchy within Transaction Sets. This will result in the rejection of the first Transaction Set (ST/SE) and acceptance of the other. One 997 acknowledgement is generated for the transmission. The acknowledgement contains rejection information for the first Transaction Set and acceptance information for the second Transaction Set.

Figure 2.3

ISA……
| **GS..***(Data here indicates that Recipient Eligibility Inquiries (270) are in the following transaction sets (ST/SE)*
| **|** **ST……..**
| **|** **|** *(Eligibility Inquiry (270) transactions)***|**
| **|** **SE……..**
| **|** *ST……..*
| **|** **|** *(Claim Status Inquiry (276) transactions)***|**
| **|** *SE…….*
| **GE…….**
IEA…….

Figure 2.3 – Invalid grouping of transactions. In this example, the Functional Group shows that only Recipient Eligibility transactions should be present but Claim Status transactions are present in the second Transaction Set. **X12 requires that Functional Groups contain only one type of transaction**. This will result in the acceptance of the first Transaction Set (ST/SE) and rejection of the other. One 997 acknowledgement is generated for the transmission. The acknowledgement contains acceptance information for the first Transaction Set and rejection information for the second Transaction Set.

Figure 2.4

ISA……
| **GS……..**
| **|** **ST……..**
| **|** **|**
| **|** **|**
| **|** **SE…….**
| **|** **ST……..**
| **|** **|**
| **|** **|**
| **|** **SE…….**
| **|** *ST……..*
| **|** **|** DMG* D8*650128*M
| **|** *SE…….*
| **|** **ST……..**
| **|** **|**
| **|** **|**
| **|** **SE…….**
| **|** **ST……..**
| **|** **|**
| **|** **|**
| **|** **SE…….**
| **|** **ST……..**
| **|** **|**

```
|       |       |
|       |       SE…….
|       |       ST……..
|       |       |
|       |       |
|       |       SE…….
|       GE…….
IEA…….
```

Figure 2.4 – Invalid format for a date field. In this example, there is one segment within one Transaction Set that contains an improperly formatted date. X12 requires dates qualified using 'D8' be 8 bytes in length. This will result in the rejection of the third Transaction Set (ST/SE) and acceptance of all the others. One 997 acknowledgement is generated for the transmission. The acknowledgement contains rejection information for the third Transaction Set and acceptance information for the other six Transaction Sets.

ADJUDICATION (MMIS) EDITING

The adjudication edits performed within the HFS MMIS enforce the Department's payment policies. These edits have been created as a result of federal Medicaid mandates, the State (of Illinois Medicaid) Plan, and the policies of HFS. Adjudication (MMIS) editing (which occurs today i.e. pre-HIPAA) will occur on transaction set(s) that have passed all Interchange level edits and HIPAA X12 edits as defined previously in this document. Adjudication edit failures will result in the rejection of the claim or service section containing the error(s), **not** the entire transaction set (ST-SE). These will be reported in the 835 Electronic Remittance Advice transaction.

Examples:

- The recipient name and number submitted on the claim do not match the HFS recipient data base information.
  Claim contains: Mary Smith, 123456789
  Database contains: John Jones, 123456789

- The diagnosis code on the claim is not a valid ICD-9 diagnosis code.

Pictorial Representation:

Figure 3.1

```
ISA…….
|       GS……..
|       |       ST……..
|       |       |       Claim #1
|       |       |       |
|       |       |       Claim #99 fails MMIS edit
|       |       |       |
|       |       |       Claim #1000
```

```
|       |       SE…….
|       |       ST……..
|       |       |       Claim #1001
|       |       |       |
|       |       |       |
|       |       |       Claim #4000
|       |       SE…….
|       GE…….
IEA……
```

Figure 3.1 – This transaction passes all front end edits (both Interchange and WEDI Types 1 – 4). One 997 acknowledgement is generated for the transmission. The acknowledgement contains acceptance information for both Transaction Sets. All claims are passed into the adjudication system. During adjudication (MMIS) editing, one claim fails. This claim will be reported as rejected on both the paper remittance advice and within the electronic remittance advice transaction (835). The failure of this claim will not affect the adjudication of the other claims submitted in this transmission.

Translator components and limitations

The State of IL is using the Mercator translator when processing electronically transmitted X12 formatted transactions. This translator can be thought of as a gateway in to and out of HFS's adjudication system. The translator will be used to interrogate transmissions to ensure X12 compliance, generate any appropriate Functional Acknowledgment (FA) and/or error information and, where possible, notify the trading partner accordingly. In order for HFS to interact with any given trading partner, certain unique trade partner information must exist within Mercator detailing who the partner is and what the specific transactions are that they can engage in with HFS. This section will describe two specific Mercator components, outline how batch, real-time and Direct Data Entry (DDE) transmissions will process within our systems and detail certain Mercator specific limitations.

The Mercator translator includes a component referred to as the Commerce Manager (CM). At the present time, the CM component that HFS is using can validate X12/HIPAA WEDI-SNIP types I and II. This component can also perform validations to ensure that the trade partner is authorized to conduct EDI with HFS as well as verifying that they are authorized to transmit the various X12 transactions (270, 276, 837, etc.) that may be within any given transmission. The Mercator translator also includes a component referred to as Compliance Checker (CC). At the present time, the CC component HFS is using can validate X12/HIPAA WEDI-SNIP types I, II, III and IV. It should also be noted that, at the present time, the Mercator components that HFS is using are only capable of applying validation and rejecting transmissions at the Interchange (ISA/IEA), Functional Group (GS/GE), or Transaction Set (ST/SE) level. With all this in mind, HFS has chosen to validate, and when appropriate reject, inbound transmissions at the lowest possible level that Mercator presently supports. This is the Transaction Set (ST/SE) level. For certain reasons that may become clear when reading onward, HFS has chosen to setup CM to enforce WEDI-SNIP type I edits. This does NOT mean that HFS only enforces X12/HIPAA validation to WEDI-SNIP type I as you will see below. As a result of these limitations, and any work-arounds that HFS will be integrating, trading partners need to understand that multiple

functional acknowledgments MAY result depending upon the type of error these components encounter.

Batch

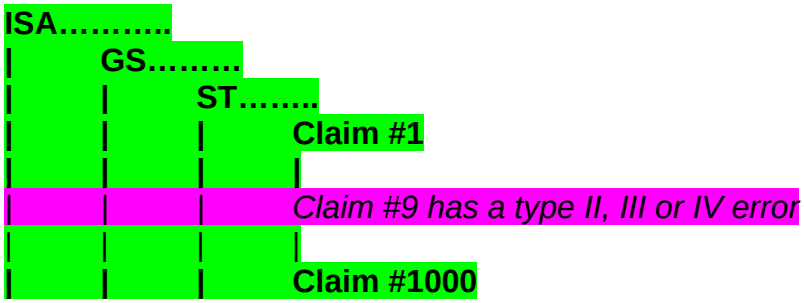
EDI transmissions containing X12 formatted transactions to be processed in a batch mode, will first be processed by the CM component. The first phase of validation that CM performs will be to ensure the trade partner has all the proper trade partner information and trade links setup with HFS to engage in each of the transaction types (270, 276, 837, etc.) it is transmitting. Next, CM will perform the X12/HIPAA compliance validation using WEDI-SNIP type I edits. Any Transaction Set (ST/SE) containing type I errors will be rejected and the appropriate 'bad' FA information (997) will be generated. Any Transaction Set (ST/SE) containing no WEDI-SNIP type I errors will result in a 'good' FA being generated as well as the Transaction Set (ST/SE) being sent forward to be processed by the CC component. The CC component will perform the X12/HIPAA compliance validation using WEDI-SNIP types I, II, III and IV. Since CM already performed WEDI-SNIP type I validation, CC should not encounter any type I errors but can encounter WEDI-SNIP type II, III or IV errors. Much like the CM component, any Transaction Set (ST/SE) CC encounters containing type I, II, II or IV errors will be rejected and the appropriate FA information (997 or 824) will be generated. Any Transaction Set (ST/SE) CC encounters containing no WEDI-SNIP type I, II, III or IV errors, and that doesn't contain trade partner errors, will be sent forward into the adjudication system. Because of these 2 distinct components (CM and CC) and the types of X12/HIPAA validation they are presently capable of or incorporated to perform, depending upon the WEDI-SNIP type of error each component might find, the result of this is a trading partner could receive multiple functional acknowledgments (FA) for the same Transaction Set ST/SE) with conflicting 'good' or 'bad' indications. The first FA will be generated from CM indicating the Transaction Set (ST/SE) is X12 compliant, but only to WEDI-SNIP type I, and the second FA (997 or 824) will be generated from CC indicating it has detected a WEDI-SNIP type II, III or IV error.

Examples:

- The trading partner sends a Functional Group (GS/GE) containing multiple Transaction Sets (ST/SE) with various types of X12/HIPAA WEDI-SNIP errors.

Pictorial Representation:

Figure 4.1



```
|       |       SE…….
|       |       ST……..
|       |       |       Claim #1001
|       |       |       |
|       |       |       |
|       |       |       Claim #4000
|       |       SE…….
|       GE…….
IEA……
```

Figure 4.1 In this example, there is one segment within the first Transaction Set that contains a WEDI-SNIP type II, II or IV error. Because of certain limitations as noted previously, this will result in a 997 acknowledgement which contains acceptance information for both Transaction Sets, to WEDI-SNIP type I, followed by a subsequent acknowledgement (997 or 824) noting the WEDI-SNIP type II, III or IV error within the first Transaction Set.

Real-Time

EDI transmissions containing X12 formatted transactions to be processed in a real-time mode, will be handled differently than those processed in batch mode. For real-time, the first phase of the validation will be performed by CC rather than by CM. The CC component will perform the X12/HIPAA compliance validation using WEDI-SNIP types I, II, III and IV. Keep in mind that X12 formatted transmissions, to be processed in a real-time mode, must contain only one Interchange (ISA/IEA), only one Functional Group (GS/GE), only one Transaction Set (ST/SE) and only one Transaction (270 or 276). Any Transaction Set (ST/SE) CC encounters containing type I, II, II or IV errors will be rejected and the appropriate FA information (997 or 824) will be generated. Unlike batch, if errors are encountered, you will not get more than a single FA (997 or 824) for any transmission and you will never get any FA (997) if the transmission passes all WEDI-SNIP types. If the Transaction Set (ST/SE) CC encounters contains no WEDI-SNIP type I, II, III or IV errors it will then be sent to CM for processing as well as sent forward into the adjudication system where the proper corresponding X12 response transaction (271 or 277) will be generated, rather than any FA, and returned to the submitter.

Direct Data Entry (DDE)

For those transactions where HFS offers a DDE capability, certain validation and editing will be performed on the front-end or within the DDE application in an interactive mode. Because of this, there will be no FA generated as a result of any DDE transaction.

Key Terms:

Transaction Set: A business grouping of data. For instance, a group of claims sent from a provider to a payer is considered a transaction set. Under HIPAA, a Transaction Set will have a Header Segment and a Trailer Segment, wrapped around various Detail Segments. The Header Segment, also known as the "ST" segment, represents the beginning of the Transaction Set whereas the Trailer Segment, also known as the "SE" segment, signifies the end of the Transaction Set. A transaction set may also be referred to as a "sub-batch".

Functional Group: A collection of one or more Transaction Sets that are like business functions. For instance, one or more groupings of Transactions Sets of claims, would be considered a Functional Group. Under HIPAA, a Functional Group will have a Header Segment and a Trailer Segment, wrapped around Transaction Set(s). The Header Segment, also known as the "GS" segment, represents the beginning of the Functional Group whereas the Trailer Segment, also known as the "GE" segment, signifies the end of the Functional Group. A functional group may also be referred to as a "batch".

Transmission Interchange: A collection of one or more Functional Groups. Under HIPAA, a Transmission Interchange will have a Header Segment and a Trailer Segment, wrapped around Functional Group(s). The Header Segment, also known as the "ISA" segment, represents the beginning of the Functional Group(s) whereas the Trailer Segment, also known as the "IEA" segment, signifies the end of the Functional Group(s). A transmission interchange may also be referred to as a "file".

Syntax and Syntax Errors: The rules and conventions that one needs to know or follow in order to validly record information, or interpret previously recorded information, for a specific purpose. Thus, a syntax is a grammar. Such rules and conventions may be either explicit or implicit. In X12 transactions, the data-element separators, the sub-element separators, the segment terminators, the segment identifiers, the loops, the loop identifiers (when present), the repetition factors, etc., are all aspects of the X12 syntax. If the mandated rules and conventions are not properly followed, the result is a syntax error. When a syntax error occurs, the result is the receiver of the information is not able to properly interpret or process the information being sent. When a syntax error occurs, it is representative that there is something fundamentally wrong with how information is being produced and communicated thereby making it impossible to interpret properly. Transaction Set(s) containing Syntax Errors will not make it into HFS's adjudication or MMIS systems. Therefore, the expected X12 response transaction may never be received (i.e. an 837 would not appear on an 835 or paper remittance advice; a 271 would not be received in response to a 270; a 277 would not be received in response to a 276).

Semantic Errors: This occurs when the value of a data element does not meet the requirements to properly represent the intent, purpose, or meaning of the data element. Examples of this would be when a data element, meant to contain a valid Recipient Number, contains invalid information OR when a data element meant to contain a HFS Recipient ID number, contains the value of a Social Security number. Transaction Set(s) containing Semantic Errors will make it into HFS's adjudication or MMIS systems where they will be processed and reported on as they are today (pre-HIPAA).

X12 and NCPDP: X12 is one of the standards HIPAA mandates for use in the communication of Electronic Data Interchange (EDI). All HIPAA mandated transactions (claims, recipient eligibility requests, etc) will use an X12 standard except for Pharmacy transactions which must use standards as set for by NCPDP.

Additional Information:

WEDI White Paper on Front-end Edits

This document is available in Adobe at
http://www.wedi.org/snip/public/articles/frontendedits_052901.pdf

Recommendations:

In general, you may want to follow these guidelines:

01) Test, test, test for X12 syntax compliance or ensure your intermediary is doing so PRIOR to engaging in EDI with HFS. This may greatly reduce the number of EDI transactions that will be rejected by HFS due to syntax errors. There are several vendors and websites that offer free X12 testing services.
02) Until systems are stabilized:
    a. Pertaining to the maximum allowable number of groups or transactions, HFS **strongly** encourages you to follow any recommendations found within the associated Implementation Guides (IG) with respect to how many 'transactions' should be grouped within any given Transaction Set (ST/SE). As an example, the 837 IG's recommend 5,000 claims per ST/SE grouping.
    b. Include only one type of transaction (Institutional claim (837I), Claim Status Inquiry (276), etc.) within an Interchange envelope (ISA/IEA).
03) Construct Interchange envelopes with only one ISA/IEA.
04) Become familiar with the standard Functional Acknowledgments (TA1, 997, 824) so problems can be understood and corrected.
05) Become familiar with Chapter 300 (Handbook for Electronic Processing) of our Provider Handbook and ensure your intermediaries have access to it.